Sedgwick CMS

INSTRUCTIONS TO THE EMPLOYER UNIT FOR COMPLETION OF THE ASRS LONG TERM DISABILITY CLAIM PACKET

1. After your employee has been off work for 2 months due to their disability, please give them the Employee LTD Claim Packet to complete. The packet should contain the following:
    a. Cover Letter
    b. Employee Claim Statement
    c. Request for information (ROI)
    d. W-4
    e. A4
    f. Direct Deposit form
    g. Attending Physician's Statement
    h. Answers to Commonly Asked Questions

2. Tell the employee to complete and sign the first six forms. Then, the employee will need to take the Attending Physician's Statement to their doctor's office and have their physician complete and sign those forms. Once this is done, all of the forms should be returned to you as soon as possible.

3. Once you receive a completed packet from the employee, you will need to complete and sign the Employer's Notice of Claim forms.

4. After steps 2 and 3 are done, you will need to fax the entire employee's packet, along with the Employer's Notice form to Sedgwick CMS. The fax number is (818) 591-7664.

5. Sedgwick CMS will keep you informed of the status of the claim through Monthly Claims Activity Reports and with email notices of the claims when they are approved, denied or terminated. You can also call Sedgwick CMS's voice response unit at (800) 495-9301, 24 hours a day, 7 days a week, to find out the status of your employee's claim. The only information you will need is the employee's Social Security Number and year of birth. If you do not receive the information you are looking for through the voice response unit, you may call between the hours of 5:00 a.m. and 5:00 p.m. Pacific Time, Monday through Friday, to speak to a Customer Service Representative.

6. If you have any questions regarding the packet, how to complete it, etc., please feel free to call Sedgwick CMS at (800) 495-9301 and you will be walked through the process.

7. If you need additional packets, please visit the ASRS website at www.azasrs.gov.

ARIZONA STATE RETIREMENT SYSTEM
LONG-TERM DISABILITY INCOME PLAN
EMPLOYER'S NOTICE OF CLAIM

Sedgwick CMS

Employer's Notice of Claim
Be sure to answer all questions
Please type or print
Fax completed forms to: (818) 591 7664

MAILING ADDRESS
SEDGWICK CMS, Inc.
P.O. Box 9830
Calabasas, CA 91372 - 0830

TO BE COMPLETED BY THE EMPLOYER New claim: ☐ Yes ☐ No

1. Full name of employee *(Please print)*

2. Date employed

3. Effective date of protection under ASRS plan

4. Social Security number

5. Amount of salary as of date disability began for purpose of ASRS:
$ _____ Gross Monthly Salary
(If school district give 1/12th of the annualized compensation)

6. Employee's normal work schedule in a fiscal year
A. Period(s) covered by contract _____
B. ___ Days per week ___ Hours per day
If you are a school district, has claimant signed a contract for the next school year? ☐ Yes ☐ No
Number of Pay periods per year _____

7. Date last worked (no. of hours that date)
_____ hrs

8. Reason for not working after this date

9. Date disability began

10. Did this disability occur as a result of the claimant's employment? ☐ Yes ☐ No ☐ Currently disputed
If "Yes," or under dispute, please provide us with the policy number, name, address and phone number of Workers Compensation administrator

11. Have you and the claimant discussed reasonable accommodations which would allow a return to work? ☐ Yes ☐ No
If "Yes" please explain.

12. Has employee resigned or been terminated? ☐ Yes ☐ No If "Yes" please give exact date:

13. Has employee returned to work? ☐ Yes ☐ No
☐ Regular duties ☐ With restrictions If "Yes" on what date?
Current work schedule:
___ Days per week ___ Hours per day

14. Has the employee ever made a prior claim for benefits? ☐ Yes ☐ No (If "Yes" please provide date returned to work.)

15. Sick leave end date

16. Vacation pay end date

17. Is the employee receiving donated leave? ☐ Yes ☐ No
If "Yes" please indicate how much they are receiving per pay period: _____ and the end date:

18 . Is the employee receiving Short - Term Disability or Mid Term Disability? ☐ Yes ☐ No
If "Yes," are the premiums paid by the ☐ Employee or ☐ Employer? If by the employer, please complete Question 19.

19. To the best of your knowledge, is the employee receiving, or is he entitled to receive, benefits from any other source such as a salary - continuance plan, other group insurance, Workers' Compensation, Social Security, Veterans Administration, retirement or pension plan, etc? ☐ Yes ☐ No If "Yes," please furnish the following information:

Name and Address Of Source	Group or Individual Basis	Policy or Claim Number, If Any	Exact Date Benefits Commenced or Will Commence	Length of Benefit Period	Amount and Frequency of Each Periodic Benefit	Total Amount of Benefits Paid

20. Remarks

Client / Plan No. 401 / 401000

Employer Name _____

ASRS Employer No. _____

Contact/Title _____

Telephone No. _____

Signature _____

Fax No. _____

Date _____

E-mail Address _____

SEDGWICK CMS ER FORM FEBRUARY 2011

Sedgwick CMS

Employer Claim Statement – Part 2
Physical / Non Physical Aspects of Job

Please complete this section of the claim statement to provide us with information concerning the physical / non physical demands of the claimant's job.

Claimant's Occupation _____

Signature / Title _____ Date: _____

Physical Requirements

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

Position	Total No. Hours	May Alternate Positions: At Will	15-30 Minutes	Hourly	Never
Sitting	___	☐	☐	☐	☐
Standing	___	☐	☐	☐	☐
Walking	___	☐	☐	☐	☐
Driving	___	☐	☐	☐	☐

2.

Claimant must	Never	Occasionally (¼ - 2 ½ hours)	Frequently (2 ½ - 5 ½ hours)	Continuously (5 ½ -8 hours)
A. Bend/Stoop	☐	☐	☐	☐
B. Climb	☐	☐	☐	☐
C. Reach above shoulder level	☐	☐	☐	☐
D. Kneel	☐	☐	☐	☐
E. Balance	☐	☐	☐	☐
F. Enter data/keystroke	☐	☐	☐	☐
G. Squat	☐	☐	☐	☐
H. Crawl	☐	☐	☐	☐
I. Crouch	☐	☐	☐	☐
J. Lift: Usual ___ lbs.	☐	☐	☐	☐
Max ___ lbs.	☐	☐	☐	☐
K. Carry Usual ___ lbs.	☐	☐	☐	☐
Max ___ lbs.	☐	☐	☐	☐
L. Push/Pull Usual ___ lbs.	☐	☐	☐	☐
Max ___ lbs.	☐	☐	☐	☐

3. On the job, claimant uses feet repetitive movements as in operating foot controls.
   Right ☐ Yes ☐ No Left ☐ Yes ☐ No Both ☐ Yes ☐ No

4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right	☐	☐	☐
B. Left	☐	☐	☐

5. Does job require:
   A. Working at unguarded heights? ☐ Yes ☐ No
   B. Exposure to marked changes in temperature and humidity or extremes thereof? ☐ Yes ☐ No
   C. Exposure to dust, fumes, gases, chemicals? ☐ Yes ☐ No

Stress / Non Physical

1. Percentage of time claimant spends answering customer complaints. ____ %
2. Percentage of claimant's work primarily judged on production. ____ %
3. Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks? ☐ Yes ☐ No ____ % of time
4. How many employees does this claimant supervise? _____
5. Is this claimant routinely subject to close supervision? ☐ Yes ☐ No
6. Percentage of time spent by the claimant working with his/her co-workers. ____ %
7. Percentage of claimant's time spent on:
   ____ % Prescheduled activities ____ % Random activities
8. Percentage of time claimant spends meeting deadlines set by others. ____ %
9. Percentage of responsibility the claimant has for the performance of his/her particular department. ____ %